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Issue Date: 30 November 2004

In the Matter of: Case No.: 2003-BLA-5832

TOM ERKER
Claimant

v.

PEABODY COAL CO.
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

Appearances: Mr. Vernon L. Plummer, II, Attorney
For Claimant

Mr. Scott A. White, Attorney
For Employer

Before: Richard T. Stansell-Gamm
Administrative Law Judge

DECISION AND ORDER – AWARD OF BENEFITS

This matter involves a claim filed by Mr. Tom Erker for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

Procedural Background

First Claim

In May 1973, Mr. Erker filed a claim with the Social Security Administration ("SSA") for black lung disability benefits.[1] On September 25, 1973, SSA denied his claim. Mr. Erker asserted that upon a subsequent amendment to the Act, he did not receive an election card to request reconsideration of his claim under the new standards (DX 1).[2]

Second Claim

Mr. Erker filed his second application for Black Lung disability benefits on August 24, 1981. On December 28, 1981, the District Director subsequently informed Mr. Erker that the medical evidence did not show that he was totally disabled from a respiratory standpoint. Mr. Erker appealed the denial in January 1982. Upon reconsideration, the District Director again denied the claim in mid-August 1982. After additional medical evaluations and tests were conducted, Mr. Erker requested a hearing on August 15, 1983. However, because Mr. Erker's hearing request was untimely and the record had closed in December 1982, it was considered as a request for modification and denied in early November 1983 on the basis that the most recent evidence did not establish total disability. On November 20, 1983, Mr. Erker requested a formal hearing and his case was referred to the Office of Administrative Law Judges in February 1984 ("OALJ").

After referral to OALJ, Administrative Law Judge Richard Huddleston conducted a hearing on September 26, 1986. At that time, based on the District Director's prior findings, Judge Huddleston dismissed Peabody Coal Company as the responsible operator. However, to permit the Claimant additional time to consider the SSA election issue, Judge Huddleston continued the proceedings.

After conducting a telephone conference in April 1987 on the status of the case, Judge Huddleston reconsidered his dismissal of the responsible operator and issued an order in June 1987 again dismissing Peabody Coal Company from the case. In a subsequent telephone conference call, counsel for the Claimant agreed that a decision on the record should be rendered.

On July 17, 1987, Judge Huddleston issued a decision denying Mr. Erker's claim for benefits. Based on the application of "true doubt" in regards to the radiographic evidence, Judge Huddleston determined Mr. Erker established the presence of pneumoconiosis. However, Mr. Erker did not prove that he was totally disabled. Mr. Erker timely filed a motion for reconsideration of his claim on a procedural issue. Judge Huddleston denied the motion on October 7, 1987. Apparently, Mr. Erker did not appeal the adverse decision (DX 1).

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[1]The record before me does not contain a copy of Mr. Erker's first claim.

[2]The following notations appear in this decision to identify exhibits: DX – Director exhibit; CX – Claimant exhibit; EX – Employer exhibit; ALJ – Administrative Law Judge exhibit; and TR – Transcript.

Third, and Present Claim

On June 17, 2002, Mr. Erker filed his third and present claim for disability benefits (DX 3). On October 16, 2002, a claims examiner issued a notice indicating that Mr. Erker would be entitled to benefits if a decision was issued at that time; however, the parties were provided an opportunity to file additional evidence (DX 27). After several extensions of the deadlines for submitting evidence, on March 12, 2003, the District Director determined that Mr. Erker had proven all four elements of entitlement (DX 35). On March 18, 2003, the Employer objected to the award of benefits (DX 37). As a result, on April 10, 2003, the District Director initiated the payment of interim benefits (DX 39). The case was forwarded to the OALJ on April 29, 2003 (DX 42). Pursuant to a Notice of Hearing, dated July 3, 2003 (ALJ I), I conducted a hearing in Springfield, Illinois on October 28, 2003 attended by Mr. Erker, Mr. Plummer and Mr. White.

Evidentiary Discussion

CX 1 and EX 9

At the hearing, an issue arose concerning Dr. Cohen's interpretation of a chest x-ray and the Employer's access to the film. Specifically, while Dr. Cohen appeared to have interpreted a January 21, 2003 chest x-ray, the copy forwarded to Dr. Renn for his assessment was dated March 10, 2003. Counsel for the Employer was uncertain whether Dr. Cohen and Dr. Renn were looking at the same x-ray. If so, then the Employer sought to submit EX 9, Dr. Renn's evaluation of the image dated March 10, 2003. If not, then the Employer sought a copy of the January 21, 2003 chest x-ray for evaluation.

I deferred a decision on the admissibility of a chest x-ray interpretation by Dr. Cohen and his corresponding medical report, marked CX1, pending: a) determination of the date of x-ray that he interpreted; and, b) production of an additional x-ray (if it exited) for Employer to permit a re-reading of the additional chest x-ray. At the close of the hearing, I left the record open for 30 days to permit resolution of both conditions.

On November 18, 2003, counsel for the Claimant submitted a letter from Dr. Robert Cohen, marked CX 2, which established the date of the chest x-ray he interpreted as January 21, 2003. Dr. Cohen explained that Mr. Erker's chest x-ray was taken on January 21, 2003 and recorded digitally. The image was stored in the hospital computer and available for viewing, but the digital image was not printed until March 10, 2003. On March 12, 2003, Dr. Cohen read the print of the digital image, in addition to reviewing the image on the radiology imaging system and provided his interpretation of the image, which was submitted with CX 1.

Based on the physician's explanation (CX 2), I conclude Dr. Cohen and Dr. Renn reviewed the same x-ray taken on January 21, 2003, stored on a hospital computer, and printed on March 10, 2003. As a result, I will admit Dr. Cohen's chest x-ray interpretation and medical report, CX 1, and Dr. Renn's response, EX 9. I also admit CX 2, Dr. Cohen's explanation of the January 21, 2003 x-ray, as a supplemental report.

Digital chest x-ray

Because the copy of the January 21, 2003 chest x-ray sent to Dr. Renn was in digital-form, counsel for the Employer also raised an objection concerning parity between the images evaluated by Dr. Cohen and Dr. Renn. He asserted that Dr. Cohen would have an advantage over Dr. Renn if Dr. Cohen was able to review the actual film rather than a digitalized copy. As Dr. Cohen subsequently explained (CX 2), the chest x-ray was taken digitally and no actual film was produced. As a result, both Dr. Cohen and Dr. Renn were reviewing a digital image and had essentially equal opportunity to evaluate the study. Thus, the Employer's objection concerning equality of the images is over-ruled.

Another issue arising from the submission of the chest x-ray taken on January 21, 2003 is the relative probative value of a digital image print-out. According to 20 C.F.R. § 718.102, a chest x-ray shall conform to the requirements set forth in Appendix A of 20 C.F.R. § 718. That appendix states "Every chest roentgenogram shall be a single postero-anterior projection at full inspiration on a 14 by 17 inch *film* [emphasis added]." If a chest x-ray does not meet one or more of the standards, then the x-ray may be accorded diminished probative value.[3] Consequently, because a digital image print-out is not printed on x-ray film as required, the interpretations of the chest x-ray taken on January 21, 2003 and printed March 10, 2003 may not be as probative as the evaluations of other chest x-rays presented on film.[4]

Evidentiary limitations

Dr. Cohen's Evaluation

In discussing rebuttal chest x-ray interpretations to the Employer's case-in-chief x-rays, counsel for the Claimant noted that he had initially received an interpretation by Dr. Fallah of a December 2002 chest x-ray. Yet, close to the hearing, the Employer apparently decided to submit Dr. Spitz's interpretation instead (TR, pages 22 and 23). As a result, Dr. Fallah's interpretation is not in the record. Upon adjudication of the claim, I discovered that Dr. Cohen had included Dr. Fallah's ambiguous interpretation[5] in his consideration of the medical record (CX 1).

Under 20 C.F.R. §§ 725.414 (a) (3) (i), a medical report may reference only medical information that is otherwise admissible under the regulations. I have considered whether Dr. Cohen's opinion is inadmissible because he included Dr. Fallah's interpretation in his evaluation.

[3]A letter from the Department of Labor, which was marked ALJ 2, indicates that the digital print-out of the x-ray was excluded from consideration by the Claims Examiner in the Office of Workers' Compensation Programs ("OWCP") because it was not in "substantial compliance" with the 20 C.F.R. §725.406 standard.

[4]Based on the annotations by Dr. Spitz (EX 3) and Dr. Renn (EX 7, offered not admitted), the December 4, 2002 chest x-ray was also produced digitally.

[5]According to Dr. Cohen's summary, in the December 4, 2002 chest x-ray, Dr. Fallah observed coarse interstitial opacities consistent with pulmonary fibrosis. The physician stated Mr. Erker's history of black lung disease would have such a radiographic appearance. At the same time, Dr. Fallah also commented the imaging was consistent with silicosis, sarcoid, or any other chronic interstitial lung disease.

However, I find presence of Dr. Fallah's mixed opinion has little significance because Dr. Cohen interpreted a subsequent January 2003 chest x-ray as positive for pneumoconiosis. As a result, I conclude Dr. Fallah's uncertain interpretation had little or no effect on Dr. Cohen's opinion and the inclusion of the interpretation in Dr. Cohen's report does not require exclusion of Dr. Cohen's findings.

Dr. Tuteur's Evaluation

Three evidentiary issues exist concerning Dr. Tuteur's pulmonary examination report, EX 5. First, at the hearing, counsel for the Employer indicated that its two case-in-chief chest x-rays were Dr. Spitz's interpretations of a July 29, 2002 chest x-ray and December 4, 2002 chest x-ray (TR, page 19). However, Dr. Tuteur's December 4, 2002 pulmonary examination report also contains his own interpretation of the December 4, 2002 chest x-ray. That third interpretation exceeds the regulatory evidentiary limits established by 20 C.F.R. §725.414 (a) (3) (i). Consequently, Dr. Tuteur's chest x-ray interpretation is not admissible and I will not consider it during my evaluation of the radiographic evidence.

Second, by considering Dr. Fallah's interpretation of the December 4, 2002 chest x-ray, Dr. Tuteur, like Dr. Cohen, has included in his opinion evidence that is not in record and not otherwise admissible since the Employer has reached its limits on case-in-chief x-ray interpretations.

In light of the above two issues, the third evidentiary issue concerns Dr. Tuteur's consideration of medical evidence not in the record. I have considered whether the first two evidentiary issues invalidate Dr. Tuteur's entire medical report. However, I conclude Dr. Tuteur's x-ray interpretation and review of Dr. Fallah's finding do not render his medical report inadmissible. His belief that the December 4, 2002 chest x-ray showed the presence of bilateral interstitial infiltrates neither establishes nor refutes the presence of pneumoconiosis. Further, as discussed above with Dr. Cohen, due to the ambiguous nature of Dr. Fallah's interpretation, its inclusion in Dr. Tuteur's opinion had little or no effect on his opinion. I also note that Dr. Tuteur's positive interpretation of a CT scan was the principle evidence supporting his diagnosis of coal workers' pneumoconiosis.

Dr. Renn's evaluation

As part of his record review, Dr. Renn interpreted the December 4, 2002 chest x-ray. His interpretation was marked EX 7 and was not admitted at the hearing because the Employer had reached the limit for case-in-chief x-rays; and I will not consider the interpretation when evaluating the radiographic evidence. Nevertheless, as with the other physicians noted above, Dr. Renn's opinion contains reference to inadmissible evidence. However, because Dr. Renn determined the December 4, 2002 chest x-ray was unreadable due to its digitalized form, its inclusion in his opinion had no effect on his assessment. Absent any significant impact, the inclusion of Dr. Renn's evaluation of the December 4, 2002 chest x-ray does not require rejection of this medical opinion.

Summary

Accordingly, my decision in this case is based on the hearing testimony and the documents admitted into evidence: DX 1 to DX 43, CX 1, CX 2, EX 1 to EX 6, and EX 8 to EX 10.

ISSUES

1. Whether, in filing a subsequent claim on June 17, 2002, Mr. Erker has demonstrated that a change has occurred in one of the conditions, or elements, of entitlement, upon which the denial of his prior claim was based in October 1987.

2. If Mr. Erker establishes a change in one of the applicable conditions of entitlement, whether he is entitled to benefits under the Act.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Stipulations of Fact

At the hearing, the parties stipulated to the following facts: a) Mr. Erker's length of coal mine employment was at least 35 years; b) Peabody Coal Company is the responsible operator in this case; c) Mrs. Catherine Erker is a dependent for the purpose of augmenting any benefits that may be payable; and d) Mr. Erker can no longer perform his coal mine employment (TR, pages 44, 45, and 52).

Preliminary Findings

Born on March 24, 1920, Mr. Erker married Mrs. Catherine Erker on May 17, 1975. Mr. Erker started mining coal in 1941 and continued mining coal until he retired on March 31,1982, except for almost four years when he served in the Army as a medic during World War II. During his last coal mine employment, Mr. Erker was a belt man, working in an underground mine in Illinois where the coal was seven to eight feet high. As a belt clean-up man, he engaged in heavy labor, which included shoveling coal dust weighing at least 25 pounds and lifting it six feet off the ground, over his head and onto the belt. Mr. Erker does not know where he would have been exposed to asbestos (DX 1, DX 3, DX 7, EX 1, and TR, pages 47 to 52).

Mr. Erker's breathing problems got very serious in the year preceding the hearing. He experiences shortness of breath with any exertion. Mr. Erker uses oxygen therapy all of the time to help his breathing; however, he does not take any medication for that purpose. Mr. Erker cannot engage in any activities that require exertion. Mr. Erker started smoking cigarettes around age 14 or 16. He smoked, though not continuously, about a half a pack of cigarettes per day[6] until 1969 when he stopped smoking entirely (DX 1, DX 26, EX 1 and TR, pages 53 to 58).

[6]Because he rolled his own cigarettes using Bull Durham tobacco, Mr. Erker had difficulty estimating how many cigarette packs he consumed a day. He estimated that he smoked about a half a pack of cigarettes per day.

Issue #1 – Change in Applicable Condition of Entitlement

Any time within one year of a denial or award of benefits, any party to the proceeding may request a reconsideration based on a change in condition or a mistake of fact made during the determination of the claim; 20 C.F.R. § 725.309 (c) and 20 C.F.R. § 725.310. However, after the expiration of one year, the submission of additional material or another claim is considered a subsequent claim which will be considered under the provisions of 20 C.F.R. § 725.309 (d). That subsequent claim will be denied unless the claimant can demonstrate that at least one of the conditions of entitlement upon which the prior claim was denied (applicable condition of entitlement) has changed and is now present. If a claimant does demonstrate a change in one of the applicable conditions of entitlement, then generally findings made in the prior claim(s) are not binding on the parties 20 C.F.R. § 725.309 (d) (4). Consequently, the relevant inquiry in a subsequent claim is whether evidence developed since the prior adjudication would now support a finding of a previously denied condition of entitlement.

The court in *Peabody Coal Company v. Spese*, 117 F.3d 1001, 1008 (7th Cir. 1997) put the concept in clearer terms:

> The key point is that the claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial. His theory of recovery on the new claim must be consistent with the assumption that the original denial was correct. To prevail on the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application.

In adjudicating a subsequent claim by a living miner in which the applicable conditions of entitlement relate to the miner's physical condition, I focus on the four basic conditions, or elements, a claimant must prove by preponderance of the evidence to receive black lung disability benefits under the Act. First, the miner must establish the presence of pneumoconiosis.[7] Second, if a determination has been made that a miner has pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment.[8] Third, the miner has to demonstrate he is totally disabled.[9] And fourth, the miner must prove the total disability is due to pneumoconiosis.[10]

With those four principle conditions of entitlement in mind, the next adjudication step requires the identification of the conditions of entitlement a claimant failed to prove in the prior claim. In that regard, of the four principle conditions of entitlement, the only elements that are capable of changing are whether a miner has pneumoconiosis or whether he is totally disabled. *Lovilia Coal Co. v. Harvey*, 109 F.3d 445 (8th Cir. 1997). That is, the second element of entitlement (pneumoconiosis arising out of coal mine employment) and the fourth element (total

[7]20 C.F.R. § 718.202.

[8]20 C.F.R. § 718.203 (a).

[9]20 C.F.R. § 718.204 (b).

[10]20 C.F.R. § 718.204 (a).

disability due to pneumoconiosis) require preliminary findings of the first element (presence of pneumoconiosis) and the third element (total disability).

In Mr. Erker's case, his most recent, prior claim was finally denied in October 1987 for failure to prove that he is totally disabled from a respiratory standpoint. However, because the underlying finding on the presence of pneumoconiosis rested on the subsequently invalid principle of "true doubt," I informed the parties at the hearing that I would evaluate the evidence developed since 1987 to determine whether Mr. Erker can now prove that he is totally disabled or has pneumoconiosis (TR, page 43).

Total Disability

To receive black lung disability benefits under the Act, a claimant must have a total disability due to a respiratory impairment or pulmonary disease. If a coal miner suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability. 20 C.F.R. §§ 718.204 (b) and 718.304. If that presumption does not apply, then according to the provisions of 20 C.F.R. §§ 718.204 (b) (1) and (2), in the absence of contrary evidence, total disability in a living miner's claim may be established by four methods: (i) pulmonary function tests; (ii) arterial blood-gas tests; (iii) a showing of cor pulmonale with right-sided, congestive heart failure; or (iv) a reasoned medical opinion demonstrating a coal miner, due to his pulmonary condition, is unable to return to his usual coal mine employment or engage in similar employment in the immediate area requiring similar skills.

While evaluating evidence regarding total disability, an administrative law judge must be cognizant of the fact that the total disability must be respiratory or pulmonary in nature. In *Beatty v. Danri Corp. & Triangle Enterprises and Dir., OWCP*, 49 F.3d 993 (3d Cir. 1995), the court stated, in order to establish total disability due to pneumoconiosis, a miner must first prove that he suffers from a respiratory impairment that is totally disabling separate and apart from other non-respiratory conditions.

Mr. Erker has not presented evidence of cor pulmonale with right-sided congestive heart failure and the record contains no evidence of complicated pneumoconiosis. As a result, Mr. Erker must demonstrate total respiratory or pulmonary disability through arterial blood-gas tests, pulmonary function tests, or medical opinion.

Arterial Blood Gas Studies

Exhibit	**Date / Doctor**	**pCO^2 (rest) pCO^2 (exercise)**	**pO^2 (rest) pO^2 (exercise)**	**Qualified[11]**	**Comments**
DX 12	March 4, 2002	40.8	54.9	Yes[12]	

[11]To qualify for Federal Black Lung Disability benefits at a coal miner's given pCO^2 level, the value of the coal miner's pO^2 must be equal to or less than corresponding pO^2 value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

[12]For the pCO^2 of 40 to 49, the qualifying pO^2 is 60, or less.

DX 15	July 31, 2002 Dr. Drake	43	50	Yes	Resting severe hypoxia.[13]
DX 10	Sept. 4, 2002 St. Vincent's Hospital	40.8	54.0	Yes	
EX 5	Dec. 4, 2002 Dr. Tuteur	37.6 30.4	50 48	Yes[14] Yes[15]	Moderate Hypoxemia
CX 1	Jan. 22, 2003 Dr. Cohen	36.2	53.5	Yes[16]	

All five of the arterial blood gas studies conducted after the denial of his most recent prior claim was denied qualify for total disability. As a result, Mr. Erker may be able to establish through the preponderance of the qualifying arterial blood gas tests that he has become totally disabled under 20 C.F.R. § 718.204 (b) (2) (ii). Under the provisions of that section, if the preponderance of the arterial blood gas studies qualify under Appendix C of Section 718, then in the absence of evidence to the contrary, the arterial blood gas test evidence shall establish a miner's total disability. Adjudication under this regulatory section requires a five step process.

First, an administrative law judge must determine whether the tests conform to the arterial blood-gas study procedural requirements in 20 C.F.R. §718.105. Second, the results are compared to the qualifying values for the various tests listed in Appendix C to determine whether the test qualifies. Third, an administrative law judge must evaluate any medical opinion that questions the validity of the test results. Fourth, a determination must be made whether the preponderance of the conforming and valid pulmonary function tests supports a finding of total disability under the regulation. Fifth, if the preponderance of conforming tests establishes total disability, an administrative law judge then reviews all the evidence of record and determines whether the record contains "contrary probative evidence." If there is contrary evidence, then it must be given appropriate evidentiary weight and a determination is made to see if it outweighs the pulmonary tests that support a finding of total respiratory disability. *Fields v. Island Creek Coal Co*., 10 B.L.R. 1-19, 1-21 (1987).

With these guidelines in mind, I first observe that the qualifying tests appear to conform to procedural requirements and the validity of the tests has not been questioned. The July 31, 2002 study was even validated by a Department of Labor physician. Since all of the tests are qualifying, total disability is clearly established by a preponderance of the evidence.

Finally, no contrary evidence has been presented to indicate Mr. Erker does not suffer a total respiratory impairment. To the contrary, every physician who provided an opinion since the first qualifying blood gas study in March 2002 as to whether Mr. Erker suffers a total respiratory disability has agreed that he is unable to return to his former employment as a coal miner,

[13]Dr. Katzman validated the arterial blood gas study (DX 17).

[14]For the pCO^2 of 37, the qualifying pO^2 is 63, or less

[15]For the pCO^2 of 30, the qualifying pO^2 is 70, or less.

[16]For the pCO^2 of 36, the qualifying pO^2 is 64, or less.

thereby rendering him totally disabled.[17] Consequently, Mr. Erker has proven through arterial blood gas studies that he is now totally disabled. Additionally, having established that one of the conditions of entitlement that he previously failed to prove has changed and is now present, Mr. Erker has satisfied the provisions of 20 C.F.R. §725.309. As a result, I must now examine the entire medical record to determine whether Mr. Erker is entitled to black lung disability benefits.

Issue #2 – Entitlement to Benefits

As previously discussed, to receive benefits under the Act, Mr. Erker must prove by the preponderance of the probative evidence that he has pneumoconiosis that arose out of his coal mine employment and that he is totally disabled due to coal workers' pneumoconiosis.

Pneumoconiosis

"Pneumoconiosis" is defined as a chronic dust disease arising out of coal mine employment.[18] The regulatory definitions include both clinical, or medical pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as "any chronic lung disease arising out of coal mine employment."[19] The regulation further indicates that a lung disease arising out of coal mine employment includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. § 718.201 (b). As courts have noted, under the Act, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

According to 20 C.F.R. §718.202, the existence of pneumoconiosis may be established by four methods: chest x-rays (§ 718.202 (a)(1)), autopsy or biopsy report (§ 718.202 (a)(2)), regulatory presumption (§ 718.202 (a)(3)),[20] and medical opinion (§ 718.202 (a)(4)). Since the record does not contain evidence that Mr. Erker has complicated pneumoconiosis, and he filed his claim after January 1, 1982, a regulatory presumption of pneumoconiosis is not applicable. In addition, he has not submitted a biopsy report and the record obviously does not contain an autopsy report. As a result, Mr. Erker will have to rely on chest x-rays or medical opinion to establish the presence of pneumoconiosis.

[17]This concurrence of recent medical opinion also establishes total disability under 20 C.F.R. § 718.204 (b) (2) (iv).

[18]20 C.F.R. § 718.201 (a).

[19]20 C.F.R. § 718.201 (a) (1) and (2).

[20]If any of the following presumptions are applicable, then under 20 C.F.R. § 718.202 (a)(3), a miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. § 718.304 (if complicated pneumoconiosis is present, then there is an irrebuttable presumption that the miner is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982, if the miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. § 718.306 (a presumption when a survivor files a claim prior to June 30, 1982).

Chest X-Rays

The following table summarizes all chest x-ray interpretations admitted into evidence:

Date of x-ray	Exhibit	Physician	Interpretation
May 25, 1979	DX 1	(Reported by Dr. Merchant)	Positive for pneumoconiosis, profusion category 1[21]
March 3, 1983	DX 1	Dr. Lewis	Minimal interstitial fibrosis, compatible with pneumoconiosis
January 20, 1986	DX 1	Dr. Snyder	Mild interstitial fibrotic changes
(same)	DX 1	Dr. Paul	Mild interstitial fibrosis, possibly due to coal dust inhalation
(same)	DX 1	Dr. Bridges	Positive for pneumoconiosis, profusion 1/2, type s/t opacities;[22] emphysema present.
(same)	DX 1	Dr. Renn, B[23]	Negative for pneumoconiosis, profusion 0/1, type s/t opacities
(same)	DX 1	Dr. Morgan	Negative for pneumoconiosis, profusion 0/1, type q/t opacities
(same)	DX 1	Dr. Traughber	Positive for pneumoconiosis, profusion 2/2, type t opacities
January 13, 1993	DX 10	Dr. Manuat	Fine reticulolinear and small nodular densities throughout lungs consistent with interstitial fibrosis, secondary to pneumoconiosis or granulomatous disease
Dec. 15, 1993	DX 11	Dr. Sherrick	Diffuse reticulonodular infiltrate in both lungs most likely due to idiopathic pulmonary fibrosis; can not exclude pneumoconiosis

[21]The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1 / 2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Or, a reading of 0/0 means the doctor found no, or few, opacities and didn't see any marks that would cause him or her to seriously consider category 1. Additionally, according to 20 C.F.R. § 718.102 (b), a profusion reading of 0/1 does <u>not</u> constitute evidence of pneumoconiosis.

[22]There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

[23]The following designations apply: B – B reader, and BCR – Board Certified Radiologist. These designations indicate qualifications a person may posses to interpret x-ray film. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds including images of the lungs. *See also* 20 C.F.R. § 718.202 (a) (1) (ii).

February 7, 1994	DX 10	Dr. Manuat	Bilateral interstitial fibrotic changes
March 10, 1995	DX 10	Dr. Manuat	Bilateral interstitial fibrosis
June 27, 1996	DX 10	Dr. Manuat	Bilateral basal interstitial fibrotic changes
August 2, 1997	DX 10 & DX 12	Dr. Lake	Moderately extensive old interstitial fibrosis bilaterally
February 16, 1999	DX 9 & DX 11	Dr. Kuhn	Bilateral infiltrates, possible chronic fibrosis
April 5, 1999	DX 10 & DX 12	Dr. Lake	Moderately extensive interstitial fibrosis bilaterally
(same)	DX 10 & DX 12	Dr. Snodsmith, BCR[24]	Extensive bilateral fibrotic changes and scattered areas of pleural density with no definite pleural calcifications seen
October 30, 2001	DX 10	Dr. Snodsmith, BCR	Relatively extensive scattered fibrotic-appearing density bilaterally and some scattered indistinct opacities and pleural changes compatible with scattered pleural plaques, chronic fibrosis and asbestos exposure
July 3, 2002	DX 13	Dr. Moore	Extensive interstitial infiltrate, chronic appearance
July 29, 2002	DX 18 & DX 19	Dr. Long, BCR, B	Positive for pneumoconiosis, profusion 2/2, type t/u opacities; "asbestos could have [caused] the above findings, although there are no radiographic findings suggestive of asbestos-related pleural disease."
(same)	EX 2 & EX 4	Dr. Spitz, BCR, B	Negative for pneumoconiosis, basilar and peripheral infiltrate consistent with pulmonary fibrosis
Dec. 4, 2002	EX 3 & EX 4	Dr. Spitz, BCR, B	Negative for pneumoconiosis
Jan. 21, 2003[25]	EX 8 & EX 9	Dr. Renn, B	Unreadable, digitalized
(same)	CX 1	Dr. Cohen, B	Positive for pneumoconiosis, profusion 3/2, type t/q opacities, emphysema present

Of the sixteen chest x-rays in the record, ten of the films are not probative on the issue of whether the films establish pneumoconiosis. The physicians who reviewed the following x-rays: January 13, 1993, December 15, 1993, February 7, 1994, March 10, 1995, June 27, 1996, August 2, 1997, February 16, 1999, April 5 1999, October 30, 2001, and July 3, 2002, found the presence of fibrosis in Mr. Erker's lungs but did not, or could not, definitively determine whether pneumoconiosis was present. A finding of fibrosis neither refutes nor establishes the presence of pneumoconiosis in Mr. Erker's lungs. Therefore, these ten x-rays are inconclusive.

Next, concerning the January 20, 1986 and July 29, 2002 chest x-rays, the physicians disagreed. In the January 20, 1986 film, Dr. Bridges and Dr. Traughber found the presence of

[24]As I informed the parties at the hearing (TR, page 43), I take judicial notice of Dr. Snodsmith's board certification and have attached the certification documentation.

[25]Dr. Renn indicated that the date of the x-ray was March 10, 2003. As previously discussed, Dr. Cohen has subsequently clarified that the March 10, 2003 image was a digital copy of the chest x-ray taken on January 21, 2003 (CX 2).

pneumoconiosis. Dr. Paul was uncertain whether the observed mild fibrosis was related to pneumoconiosis. However, Dr. Synder, Dr. Renn, and Dr. Morgan did not find sufficient evidence to diagnose pneumoconiosis. Since Dr. Paul was uncertain about his interpretation, the consensus of Dr. Synder, Dr. Renn and Dr. Morgan that the film is negative outweigh the contrary opinions of Dr. Bridges and Dr. Traughber. As a result, I find the January 20, 1986 is negative for pneumoconiosis.

Turning to the dispute regarding the July 29, 2002 radiographic digital study, Dr. Long and Dr. Spitz disagree on whether the film shows the presence of pneumoconiosis. Since both doctors are equally well qualified to interpret the film, their disagreement renders the July 29, 2002 chest x-ray inconclusive.

In light of the physician's comments, the December 4, 2002 and January 21, 2003 chest x-rays were digital in form. Dr. Spitz interpreted the first x-ray as negative; Dr. Cohen found the second study positive for pneumoconiosis. Based on their sole interpretations, I find the December 4, 2002 film is negative and the January 21, 2003 chest x-ray is positive for pneumoconiosis. However, as previously discussed, since both evaluation were based on digital images, they are slightly less probative than the other evaluations of regular chest x-ray film. but likewise has diminished evidentiary value.

Finally, there is no dispute regarding the remaining two films. The sole interpretations for the March 25, 1979 and March 3, 1983 chest x-rays were positive for pneumoconiosis.

In summary, over the course of 24 years, two chest x-rays are positive for pneumoconiosis, one chest x-ray is negative, one chest x-ray is positive with diminished probative value; another is likewise negative with reduced probative value, and eleven chest x-rays are inconclusive. Since the preponderance of the chest x-rays are inconclusive and the remaining studies further demonstrate the near even disagreement among the physicians concerning the presence of pneumoconiosis in Mr. Erker's chest x-rays, I find Mr. Erker is unable to establish through a preponderance of the radiographic evidence the presence of pneumoconiosis in his lungs under the provisions of 20 C.F.R. § 718.202 (a) (1).

Medical Opinion[26]

Although the chest x-ray evidence is insufficient, Mr. Erker may still show the presence of pneumoconiosis through documented and reasoned medical opinion in accordance with 20 C.F.R. §718.202 (a) (4). In Mr. Erker's case, several physicians have expressed an opinion about his pulmonary condition. Prior to summarizing their assessments, a review of the CT scan readings, in addition to the pulmonary function tests and blood gas studies helps place their opinions into perspective.

[26]Several of the physicians' pulmonary assessments were obtained from the treatment notes from Mr. Erker's medical record and are admissible under 20 C.F.R. § 725.414 (a) (4). I have not included the diverse treatments Mr. Erker received at St. Johns Hospital from 1993 through 1999 for non-pulmonary or non-cardiac ailments (DX 9, DX 10, and DX 11). Most of the physical examinations associated with the non-pulmonary ailments revealed clear lungs and the physicians reported Mr. Erker had stopped smoking cigarettes in 1969. During a February 1994 orthopedic hospitalization, Mr. Erker received nebulizer treatments.

CT Scans[27]

April 7, 1999 Dr. Jeffrey Brody reviewed a CT scan taken of Mr. Erker's chest. He noted the presence of calcified and non-calcified pleural plaques associated with emphysematous changes, chronic interstitial changes and some fibrosis. He also found small nodular densities that were too small to characterize and believed the changes were most consistent with granulomatous disease (DX 10 and DX 12).

October 30, 2001 Dr. John Snodsmith, a board certified radiologist, reviewed a CT scan and observed scattered pleural plaques, "thought to be pathognomonic for previous asbestos exposure," advanced chronic lung changes with scattered fibrosis and some reticulo-nodular type opacities. Dr. Snodsmith also noted fairly extensive emphysematous changes bilaterally with blebs (DX 10 and DX 12).

December 4, 2002 Dr. Harold B. Spitz, a board certified radiologist and B-reader, reviewed a CT scan taken of Mr. Erker's chest. He observed changes of emphysema and pulmonary fibrosis, which were more prevalent at the periphery and bases of the lungs. He also noted pleural plaques secondary to previous asbestos exposure, some of which were calcified. He did not find evidence of coal workers' pneumoconiosis (EX 3 and EX 4).

Dr. Cary Lynn Siegel, board certified in radiology,[28] reviewed the CT study and noted extensive calcified pleural plaque consistent with asbestos related exposure. The physician also found extensive emphysematous changes and the presence of fibrosis throughout the pulmonary parenchyma of uncertain etiology. Multiple nodules were seen throughout the lungs predominantly in the upper lobes, which may be due to silicosis[29] exposure. Dr. Siegel concluded that calcified pleural plaques are due to asbestos related exposure, upper lobe nodules bilaterally may relate to silicosis exposure and extensive pulmonary fibrosis is of uncertain etiology (EX 5).

On December 5, 2002, Dr. Bhalla provided his assessment of the CT scan, finding the presence of pleural micronodules which coalesced. While asbestos was a possibility, the physician believed that the appearance of fibrosis with random and subpleural nodules is most suggestive of "coal min[ers'] pneumoconiosis or silicosis." Specifically:

> Occasionally, the pleural plaques seen above can be seen with asbestos related diseases. However, sparing of the diaphragm and involvement of the posterior portions and upper portions is more suggestive of coal miner's pneumoconiosis or silicosis (EX 5).

[27]According to 20 C.F.R. §718.107 (a), the regulation governing the submission of other medical evidence, the results of any medically acceptable test reported by a physician and not addressed in the regulations may be admitted if it tends to demonstrate the presence or absence of pneumoconiosis.

[28]I take judicial notice of Dr. Siegel's board certification and have attached the certification documentation.

[29]The regulation definition of clinical pneumoconiosis includes silicosis. 20 C.F.R. § 718.201 (a) (1).

In conjunction with his pulmonary evaluation of Mr. Erker, Dr. Peter Tuteur also reviewed the CT scan. He first noted the study confirmed the chest x-ray observations of diffuse emphysema. Within parenchyma, he found areas of panlobular and centrilobular emphysema. The CT scan showed a pleural process with "an appearance distinctly different from the typical asbestos associated plaques. . ." Dr. Tuteur also observed areas of parenchymal nodular densities "quite typical of coal workers' pneumoconiosis." The study showed advanced simple coal workers' pneumoconiosis (EX 5).

When Dr. Renn, a B reader, evaluated the CT scan, he observed bilateral, calcified pleural plaques, bilateral, upper zone small nodules, and bullous emphysema (EX 10).

Pulmonary Function Tests

Exhibit	**Date / Doctor**	**Age / Height**	**FEV¹ pre[30] post[31]**	**FVC pre post**	**MVV pre post**	**% FEV¹ / FVC pre post**	**Qualified[32] pre Post**	**Comments**
DX 1	Sept. 25, 1981 Dr. Summer	61 69″	2.8	4.80	132	58.3	No[33]	
DX 13	July 28, 1982 Dr. Summer	62 71″	2.99 2.80	4.60 4.44	116 102	65 63	No[34] No	Mild obstruction with response to bronchodilator
DX 1	Aug. 4, 1983 Dr. Korda	63 68.5″	2.815	4.70	75	59.9	No[35]	Mild to moderate obstruction of small airways
DX 1	Jan. 20, 1986 Dr. Paul	65 71″	2.82 3.05	4.15 4.62	93 109	68 66	No[36] No	Minimal obstructive airways disease

[30]Test result before administration of a bronchodilator.

[31]Test result following administration of a bronchodilator.

[32]Under 20 C.F.R. § 718.204 (b)(2)(i), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718, **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%.

[33]The qualifying FEV1 number is 1.95 for age 61 and 68.9″; the corresponding qualifying FVC and MVV values are 2.49 and 78, respectively.

[34]The qualifying FEV1 number is 2.09 for age 62 and 70.9″; the corresponding qualifying FVC and MVV values are 2.67 and 84, respectively.

[35]The qualifying FEV1 number is 1.89 for age 63 and 68.5″; the corresponding qualifying FVC and MVV values are 2.41 and 75, respectively.

[36]The qualifying FEV1 number is 2.04 for age 65 and 70.9″; the corresponding qualifying FVC and MVV values are 2.61 and 82, respectively.

DX 10 & DX12	Nov. 5, 2001 Dr. Prabhu	81[37] 71″	1.55 1.68	2.60 2.71	73 66	59.6 62	Yes[38] Yes	Obstruction, partial response bronchodilator, suggestive of asthma
DX 10 & DX12	June 12, 2002 Dr. Prabhu	82 72″	1.63 1.78	2.33 2.76	75 77	70 64.5	Yes[39] Yes	Predominant restricted and improving obstructed airways disease
DX 16	July 29, 2002 Dr. Drake	82 70″	1.89	2.96	84.21	63.9	No[40]	
EX 5	Dec. 4, 2002 Dr. Tuteur	82 67.5″	1.86 1.91	2.96 3.02	99	62.8 63.2	No[41] No	Mild obstruction
CX 1	Jan. 22, 2003 Dr. Cohen	82 67″	1.75 1.66	3.14 3.05	70	55.7 54.4	No[42] No	Moderate obstructive defect without reversibility

Arterial Blood Gas Studies

Exhibit	**Date / Doctor**	**pCO^2 (rest) pCO^2 (exercise)**	**pO^2 (rest) pO^2 (exercise)**	**Qualified[43]**	**Comments**
DX 1	Sept. 22, 1981 Dr. Summer	31.8 33.1	63.6 67.4	Yes[44] Yes[45]	

[37]For all of the remaining pulmonary function tests taken, I am using the highest age listed in the regulations, Appendix B, Table B1 of 20 C.F.R. §718 of 71 years.

[38]The qualifying FEV1 number is 1.94 for age 71 and 70.9″; the corresponding qualifying FVC and MVV values are 2.51 and 78, respectively.

[39]The qualifying FEV1 number is 2.04 for age 71 and 72.0″; the corresponding qualifying FVC and MVV values are 2.63 and 82, respectively.

[40]The qualifying FEV1 number is 1.85 for age 71 and 69.7″; the corresponding qualifying FVC and MVV values are 2.39 and 74, respectively.

[41]The qualifying FEV1 number is 1.66 for age 71 and 67.3″; the corresponding qualifying FVC and MVV values are 2.16 and 67, respectively.

[42]The qualifying FEV1 number is 1.63 for age 71 and 66.9″; the corresponding qualifying FVC and MVV values are 2.12 and 65, respectively.

[43]To qualify for Federal Black Lung Disability benefits at a coal miner's given pCO^2 level, the value of the coal miner's pO^2 must be equal to or less than corresponding pO^2 value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

[44]For the pCO^2 of 31, the qualifying pO^2 is 69, or less.

[45] For the pCO^2 of 33, the qualifying pO^2 is 67, or less.

DX 13	July 28, 1982 (St. Vincent's Hospital)	37.5	67.6	No[46]	
DX 1	Aug. 4, 1983 Dr. Korda	39.7 40.4	67.5 73	No[47] No[48]	
DX 1	Jan. 20, 1986 Dr. Paul	40.9 40.4	66 75.5	No No	
DX 12	March 4, 2002	40.8	54.9	Yes	
DX 15	July 31, 2002 Dr. Drake	43	50	Yes	Resting severe hypoxia. Valid[49]
DX 10	Sept. 4, 2002 St. Vincent's Hospital	40.8	54.0	Yes	
EX 5	Dec. 4, 2002 Dr. Tuteur	37.6 30.4	50 48	Yes Yes[50]	Moderate hypoxemia; severe impairment
CX 1	Jan. 22, 2003 Dr. Cohen	36.2	53.5	Yes[51]	

Dr. J. L. Summer
(DX 1)

On December 15, 1981, Dr. Summer conducted a pulmonary evaluation of Mr. Erker, who was a long-term coal miner. Mr. Erker reported increasing shortness of breath over the prior two to three years. He had smoked cigarettes for eight years at the rate of a pack and a half a day; he quit in March 1969. The physical examination and pulmonary function tests were within normal limits. The arterial blood gas study indicated the presence of an oxygen transfer problem. Based on his evaluation, Dr. Summer diagnosed high blood pressure. The physician did not find any coal dust-related pulmonary condition.

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[46]For the pCO^2 of 37, the qualifying pO^2 is 63, or less.

[47]For the pCO^2 of 39, the qualifying pO^2 is 61, or less.

[48]For the pCO^2 of 40 to 49, the qualifying pO^2 is 60, or less.

[49]Dr. Katzman, for the Department of Labor, validated the arterial blood gas study (DX 17).

[50]For the pCO^2 of 30, the qualifying pO^2 is 70, or less.

[51]For the pCO^2 of 36, the qualifying pO^2 is 64, or less.

Dr. Thomas E. Brewer
(DX 1 and DX 13[52])

On July 26, 1982, Mr. Erker presented to Dr. Brewer for a black lung physical. Mr. Erker had worked in the coal mines for 42 years and had a 19 pack-year[53] history of cigarette smoking. Mr. Erker reported chronic shortness of breath upon walking some distance. The physician found bilateral expiratory rhonchi and wheezes. Dr. Brewer ordered a pulmonary function test and arterial blood gas study. He deferred writing a letter for Mr. Erker until he reviewed the pulmonary studies.

On August 9, 1982, Dr. Brewer again conducted a pulmonary examination. Mr. Erker had worked in coal mines for 42 years; he had a 19 pack-year history of cigarette smoking. Mr. Erker complained about chronic shortness of breath upon exertion. Upon physical examination, Dr. Brewer heard bilateral wheezes and rhonchi. The pulmonary function test results were less than predicted.[54] Dr. Brewer concluded that Mr. Erker was totally disabled by coal workers' pneumoconiosis.

Dr. Glennon H. Paul
(DX 1)

On January 28, 1986, Dr. Paul, board certified in internal medicine, allergy and immunology, evaluated Mr. Erker's pulmonary condition. Mr. Erker had been a coal miner for 43 years and had a 30 pack-year history of cigarette smoking. He was able to walk up to a mile without experiencing shortness of breath. A chest x-ray did not show clinically significant pneumoconiosis and the arterial blood gas study was normal. The pulmonary function test revealed a mild obstruction in the small airways. Based on his examination, Dr. Paul concluded Mr. Erker did not have any cardiac or pulmonary disease. He did not have coal workers' pneumoconiosis. Mr. Erker's mild airways obstruction was consistent with his long history of cigarette smoking.

In a subsequent deposition, Dr. Paul explained that the small airways obstruction was related to cigarette smoking in light of the abnormal FEF 25-75 result, while the total lung capacity and forced vital capacity were normal. If coal workers' pneumoconiosis were involved, Dr. Paul would expect the later two values to be abnormal. Likewise, Mr. Erker did not experience the drop in oxygen levels in his blood upon exercise which is a typical finding if pneumoconiosis were present. Although the mild fibrosis noted in the chest x-ray may be consistent with pneumoconiosis, it not does have any clinical significance. Dr. Paul based his finding that Mr. Erker did not have pneumoconiosis on the absence of any physiological impairment.

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[52]Although the DX 13 treatment note does not contain Dr. Brewer's signature, its contents and date identify the notation as his first evaluation of Mr. Erker.

[53]A pack-year equals the consumption of one pack of cigarettes per day for one year.

[54]Based on the specific values mentioned by Dr. Brewer and the date of his pulmonary examination, the physician is referring to the July 28, 1982 pulmonary function test (DX 13).

Dr. Daniel R. Hoffman
(DX 1)

On July 22, 1986, Dr. Hoffman examined Mr. Erker, who had spent 43 years as a belt operator in coal mines. He left mining in March 1982. Mr. Erker smoked cigarettes for about eight years, at the rate of a pack and a half a day; he stopped in 1969. For the past few years, Mr. Erker had been experiencing increasing shortness of breath. He was being treated for hypertension. Although the lungs were clear upon physical examination, an earlier chest x-ray revealed fibrosis consistent with pneumoconiosis. Prior pulmonary function tests established the presence of a mild to moderate airways obstruction. Based on the entire medical record, and considering Mr. Erker only smoked cigarettes for eight years, Dr. Hoffman concluded he had coal workers' pneumoconiosis.

Dr. Richard Del Valle
(DX 12)

Between March 1999 and June 2001, during regular office visits with Dr. Del Valle, who is board certified in internal medicine,[55] Mr. Erker did not present any pulmonary complaints. The physician found clear lungs. However, on October 29, 2001, Mr. Erker presented with worsening shortness of breath complaint. Mr. Erker had been previously told that he had black lung disease but his claim had been denied. Upon examination, the lungs were clear. Dr. Del Valle diagnosed shortness of breath and ordered radiographic studies. Subsequent chest x-ray and CT scan suggested exposure to asbestos and Dr. De Valle queried whether Mr. Erker had worked around asbestos.

By the time of a November 28, 2001 visit, based on pulmonary tests, Dr. Del Valle concluded Mr. Erker had emphysema with an asthma component. The physical examination showed clear lungs. Dr. Del Valle prescribed steroids and an inhaler. He diagnosed chronic obstructive pulmonary disease ("COPD") and asthma.

On March 4, 2002, Mr. Erker reported persistent shortness of breath despite the medication. Dr. Del Valle noted his history as a coal miner. The radiographic studies showed asbestos exposure. However, the lungs were clear and the pulmonary function test did not produce any significant findings. Yet, when Dr. Del Valle had Mr. Erker walk, he was surprised to find a drop in oxygen saturation. At first, the doctor believed the shortness of breath was related to Mr. Erker's obesity but realized that a component of the problem also related to poor gas exchange. Dr. Del Valle diagnosed shortness of breath with hypoxia and referred Mr. Erker to Dr. Prabhu.

On May 8, 2002, Mr. Erker seemed to be using his supplemental oxygen only at rest. He reported 43 years of coal mine employment and the use of cigarettes through 1969. Dr. Del Valle found poor airflow in the lungs. Dr. Del Valle urged Mr. Erker to use the oxygen continuously. He also encouraged him to apply for black lung benefits, "although the formal diagnosis here seems to be asbestosis."

[55]I take judicial notice of Dr. Del Valle's board certification and have attached the certification documentation.

On June 18, 2002, Mr. Erker returned to Dr. Del Valle and reported doing better with oxygen therapy. Mr. Erker expressed an interest in filing for black lung benefits and the physician thought it was a good idea. Mr. Erker again stated that he had been a coal miner and did not believe he had worked around asbestos. Mr. Erker's lungs were clear and his oxygen saturation improved with deep breaths. Dr. Del Valle diagnosed interstitial lung disease on the basis of asbestosis.

Dr. M. B. Prabhu
(DX 12)

On March 6, 2002, Dr. M.B. Prabhu, board certified in internal disease and pulmonary medicine,[56] evaluated Mr. Erker for exertional dyspnea. A former coal miner, Mr. Erker did not believe that he had ever been exposed to asbestos. He was also a nonsmoker. Mr. Erker reported shortness of breath with mild exertion, such as walking only a short distance. A chest exam revealed clear lungs. A CT scan showed pleural plaques indicative of previous asbestos exposure and bilateral interstitial reticulonodular type opacities. Dr. Prabhu also noted pulmonary fibrosis with emphysematous blebs. An arterial blood gas study produced results that were consistent with an interstitial lung disease. A pulmonary function test showed evidence of an airway obstruction with bronchodilator response, but with preserved diffusing capacity. Dr. Prabhu diagnosed: a) dyspnea related to interstitial lung disease "probably secondary" to asbestos; b) hypoxemia secondary to interstitial lung disease; and, c) pulmonary tension secondary to hypoxemia; and, d) "possibly associated obstructive airways disease." As a result, Dr. Prabhu gave Mr. Erker oxygen to protect him from pulmonary hypertension and oxyhemoglobin desaturation. Noting that a pulmonary function test showed bronchospastic component response to bronchodilation, the physician also prescribed anti-inflammatory medication.

In a March 29, 2002 visit, Mr. Erker reported little change in his condition. Although the lungs were clear, Mr. Erker's breath sounds were diminished. A CT scan had revealed pleural plaques secondary to asbestos exposure. The physician noted exercise-induced oxyhemoglobin desaturation. Because Mr. Erker's oxygen blood levels continued to drop upon exertion, Dr. Prabhu stressed the importance of continuous oxygen therapy.

On May 31, 2002, Dr. Prabhu again evaluated Mr. Erker who was resisting the oxygen therapy. The physician noted continued oxygen desaturation with exertion and stressed the importance of continuance oxygen therapy. Dr. Prabhu believed Mr. Erker had asbestos exposure with interstitial lung disease and persistent hypoxemia.

[56]I take judicial notice of Dr. Prabhu's board certification and have attached the certification documentation.

Dr. David J. Kiel
(DX 13)

On June 26, 2002, Mr. Erker presented to Dr. Kiel, board certified in family practice,[57] for a second opinion concerning asbestos/black lung. Mr. Erker was "concerned about the diagnosis of asbestosis because. . .he was never around asbestos but he worked in a coal mine all his life till he retired. . .in 1982." Mr. Erker had not smoked cigarettes since 1969. His shortness of breath had started to worsen about six months before his evaluation. Upon examination, Dr. Kiel found diminished but clear breath sounds. Pending a review of radiographic evidence, Dr. Kiel deferred a diagnosis.

On July 3, 2002, Dr. Kiel again saw Mr. Erker. Upon review of a chest x-ray, Dr. Kiel believed it "looks more like a fibrotic picture rather than anything else." He did not understand a diagnosis of classic asbestosis, "especially if there is no exposure history to asbestos and apparently 30 years of exposure to coal dust being a driller." The lungs were clear. Dr. Kiel diagnosed COPD and prescribed supplemental oxygen.

Dr. William K. Drake
(DX 14)

On July 31, 2002, Dr. William Drake, board certified in pathology,[58] conducted a pulmonary evaluation. Mr. Erker had been a coal miner for 43 years. He smoked a pack of cigarettes per day from 1934 to 1964. Mr. Erker was suffering from attacks of wheezing and complained of sputum production, wheezing, dyspnea, cough and chest pain. He is mainly hypoxic. The patient has a history of pulmonary fibrosis and some asthma and has been on continuous oxygen for a few years.

Upon examination, Dr. Drake heard vesicular breath sounds. The chest x-ray showed fibrosis consistent with coal workers' pneumoconiosis. After Mr. Erker was off oxygen for 20 minutes, the resting arterial blood gas study showed severe hypoxia. Noting Mr. Erker's sole employment as a coal miner, Dr. Drake diagnosed coal workers' pneumoconiosis. The physician also observed that a drop in oxygen saturation with the ability to "ventilate nearly normally. . . [was] quite consistent with coal workers' pneumoconiosis." Mr. Erker also had coronary arteriosclerosis. Dr. Drake considered Mr. Erker totally disabled because he is hypoxic and cannot survive without oxygen. Although heart disease is present, Dr. Drake opined that Mr. Erker's primary problem is his lung disease. He based his findings on the results of lung function tests, an x-ray and an EKG (electrocardiogram).

[57]I take judicial notice of Dr. Kiel's board certification and have attached the certification documentation.

[58]As I informed the parties at the hearing (TR, page 43), I take judicial notice of Dr. Drake's board certification and have attached the certification documentation.

Dr. Peter G. Tuteur
(EX 5 and EX 6)

On December 4, 2002, Dr. Tuteur, board certified in internal medicine and pulmonary disease, conducted a pulmonary evaluation of Mr. Erker. Mr. Erker was a coal miner from 1940 to 1982, except between 1941 and 1945 when he served in the military. He smoked a half a pack of cigarettes per day from 1934 to 1969. He did not smoke commercial cigarettes; consequently, Mr. Erker's risks for health problems associated with cigarette smoking, such as COPD, arteriosclerotic disease and/or lung cancer, were increased. Mr. Erker reported becoming breathless one year ago and began requiring oxygen with activity. He suffers from a productive cough and wheezing with exercise.

The chest exam revealed normal breath sounds. Pulmonary function tests demonstrated a mild obstructive ventilatory defect without change after bronchodilation and evidence of air trapping. At rest, Mr. Erker suffers from moderate impairment of gas exchange that worsens during exercise. His degree of impairment of gas exchange is disproportionate to his mild obstruction abnormality.

Having reviewed the chest x-ray and finding nodular densities in the CT scan consistent with pneumoconiosis, in addition to the other objective evidence, Dr. Tuteur concluded that Mr. Erker has advanced simple coal workers' pneumoconiosis. The coal workers' pneumoconiosis causes his breathlessness, hypoxemia, and accounts for the distinctive radiographic changes. Due to the coal workers' pneumoconiosis, Mr. Erker is permanently and totally disabled; he is unable to return to work as a coal miner.

Dr. Robert A. C. Cohen
(CX 1 and CX 2)

On January 21, 2003, Dr. Cohen, board certified in internal medicine and pulmonary disease, conducted a pulmonary evaluation of Mr. Erker and reviewed other medical evidence including Dr. Tuteur's and Dr. Drake's pulmonary reports, pulmonary tests from July and December 2002, Dr. Long's interpretation (positive for pneumoconiosis) of a July 2002 x-ray and Dr. Fallah's interpretation (ambiguous) of a December 2002 chest x-ray, and Dr. Siegel's and Dr. Bhalla's interpretation of the December 2002 CT scan. Mr. Erker's medical history includes a diagnosis of black lung disease in the 1970's. He presently complains of shortness of breath with minimal cough that has made daily life difficult over the course of the last year. To treat his breathing problems, he has been using home oxygen for a year. Mr. Erker smoked a half pack of cigarettes per day for 35 years, stopping in 1969. He worked in the coal mines for 40 to 41 years, mostly as a driller around "a lot of dust;" he spent his last years as a coal belt shoveler.

The lungs exhibited poor air entry. The January 2003 x-ray that Dr. Cohen read revealed the presence of pneumoconiosis in Mr. Erker's lungs. The pulmonary function test from December 2, 2002 is consistent with moderate obstructive lung disease with severe diffusion impairment. Additionally, Dr. Cohen noted that the July 29, 2002 pulmonary function test

showed a mild obstructive impairment with additional mild restrictive impairment. The arterial blood gas studies also show significant gas exchange abnormalities at rest and with exercise.

Dr. Cohen diagnosed Mr. Erker with coal workers' pneumoconiosis, chronic lung disease, chronic productive cough and worsening shortness of breath. The chest x-ray showed "severe" pneumoconiosis, which based on Mr. Erker's employment history is related to his 36 plus years of coal dust exposure. Mr. Erker also has a moderate obstructive defect with severe diffusion impairment secondary to coal dust and smoking as evidenced by the pulmonary function tests, in addition to severe gas exchange abnormalities arising from coal dust exposure and cigarette smoking. In response to the question whether Mr. Erker's pneumoconiosis rendered him unable to perform his last work as a coal miner, Dr. Cohen responded that the moderate obstructive impairment established by the pulmonary function test and the severe gas exchange abnormality at rest and exercise "clearly" disabled Mr. Erker from retuning to his last coal mine employment as a belt shoveler.

Dr. Joseph J. Renn, III
(EX 10)

On September 21, 2003, Dr. Renn, board certified in internal medicine and pulmonary disease, conducted a comprehensive medical record review in Mr. Erker's case. He considered the medical record from Mr. Erker's prior claim, his treatment records, the more recent pulmonary evaluations, chest x-ray interpretations through 2001, and CT scan interpretations from 1999, 2001 and 2002. Mr. Erker has a 43 year coal mine employment history, ending his employment in March 1982. He worked as a driller at the face of the mine. Mr. Erker smoked from 1934 to 1969 as much as 1 ½ packs of cigarettes per day, giving him an average 35 pack-year cigarette smoking history. The pulmonary function tests show that Mr. Erker has a mild lung obstruction from 1980, continuing to 2002. The January 22, 2003 pulmonary function study revealed a moderately severe obstructive pattern.[59] Lung volume studies revealed the absence of a restrictive ventilatory defect and the air trapping was consistent with an obstructive ventilatory defect. The results of diffusing capacity studies showed a severe reduction that partially corrected to normal. Arterial blood gas studies in 2002 and 2003 revealed hypoxemia, which worsened during exercise.

Dr. Renn reviewed the radiographic evidence, including a radiologist's assessment of the December 4, 2002 CT scan indicating the presence of pneumoconiosis/silicosis. Dr. Renn also re-evaluated the December 4, 2002 CT scan and observed both emphysema and small nodules in the upper lung zones. Based on his review of the medical record, Dr. Renn concluded Mr. Erker had simple coal workers' pneumoconiosis/silicosis, bullous emphysema due to his smoking history, old pulmonary granulomatous disease, and bilateral partially calcified pleural plaques of unknown etiology. The physician also believes Mr. Erker has a moderate to moderately severe obstructive ventilatory defect due to coal workers' pneumoconiosis and bullous emphysema. The physician finally opined that Mr. Erker's coal workers' pneumoconiosis results from his

[59]Dr. Renn noted the widely varying height discrepancies (67 to 72 inches) used in the various pulmonary function studies would have affected the predicted values, but not the actual observed values.

exposure to coal dust and that Mr. Erker is totally disabled and cannot perform his last coal mine job as a belt shoveler.

Discussion

The opinions of the first four physicians to consider Mr. Erker's pulmonary condition during his second claim for benefits in the mid-1980s were evenly split on whether he had pneumoconiosis. While Dr. Brewer and Dr. Hoffman found sufficient evidence for a diagnosis of black lung disease, Dr. Summer and Dr. Paul disagreed and concluded he did not have pneumoconiosis. While I have considered their dispute, I find the more relevant inquiry involves the more recent medical opinions concerning Mr. Erker's pulmonary condition because coal workers' pneumoconiosis is a progressive and latent disease.[60]

Prior to addressing those assessments, as a preliminary consideration, I note that most of the physicians relied on CT scans to support their diagnoses. However, in a manner similar to the chest x-rays, the three CT scans produced since 1999 generated conflicting interpretations. As a result, I must first determine the preponderance of the CT scan findings.

In the 1999 imaging, Dr. Brody found unspecified pleural plaques, chronic interstitial changes and some fibrosis. In the 2001 CT scan, Dr. Snodsmith observed pleural plaques consistent with asbestos exposure, scattered fibrosis and some reticulo-nodular opacities. The three pathologists who interpreted the 2002 CT study also found both pleural plaques and pulmonary fibrosis. Dr. Spitz believed the plaques were due to asbestos and specifically stated no pneumoconiosis was present. Dr. Siegel agreed that the plaques were related to asbestos. However, she also concluded that the multiple nodules scattered throughout the lungs were consistent with silicosis. Dr. Bhalla agreed with Dr. Siegel that the nodules were suggestive of pneumoconiosis or silicosis. He then explained how the pattern of the pleural plaques, coupled with their location, while suggestive of asbestos, was more consistent with pneumoconiosis. In their interpretations of the scan, Dr. Tuteur and Dr. Renn essentially concurred with Dr. Bhalla's assessment.

In resolving this radiographic professional dispute, I first find the Dr. Broudy really didn't take a position on whether his findings indicated asbestosis, pneumoconiosis, or both. Next, I give Dr. Spitz's opinion diminished probative value because he did not address the presence of nodules or opacities identified by Dr. Snodsmith, Dr. Siegel, and. Dr. Bhalla. Concerning the nodules, Dr. Snodsmith did not render a diagnosis. However, Dr. Siegel and Dr. Bhalla linked their presence to silicosis exposure and Dr. Bhalla specifically diagnosed pneumoconiosis. The consensus of these two radiologists is further supported by the evaluations of Dr. Tuteur and Dr. Renn, who found sufficient radiographic evidence in their interpretations of the 2002 CT scan to diagnose pneumoconiosis. As a result, I find the preponderance of the CT scan evidence indicates the presence of multiple nodules consistent with pneumoconiosis.

[60]*See Parsons v. Wolf Creek Colleries*, 23 B.L.R. 1-___, BRB No. 02-0188 BLA (Sept. 30, 2004) (en banc) (the potential for progressivity and latency of pneumoconiosis is inherent in every case) and *Workman v. Eastern Assoc. Coal Corp*., BRB No. 02-0727 BLA (Aug. 19, 2004) (order on recon.) (en banc).

Concerning the issue of asbestosis, Dr. Snodsmith, Dr. Spitz, and Dr. Siegel believed the pleural plaques were consistent with asbestos. Despite that consensus, I believe Dr. Bhalla's assessment is sufficiently convincing to undermine the finings of Dr. Snodsmith, Dr. Spitz, and Dr. Siegel because he was the only radiologist to integrate the presence of both pleural plaques and pulmonary nodules into a medical explanation that is reasonable and consistent with Mr. Erker's employment background, which did not involve exposure to asbestos. Specially, while acknowledging the plaques standing alone could be interpreted as asbestos-related, Dr. Bhalla explained that the specific location of the plaques within the lungs, coupled with the random fibrosis and subpleural nodules, was more suggestive of pneumoconiosis and silicosis. Consequently, I have less confidence that the CT scans show the presence of asbestosis.

Having determined that the recent CT scans contain evidence of pneumoconiosis, yet represent doubtful evidence of asbestosis, I turn to the evaluation of the recent medical opinions.

In October 2001, Dr. Del Valle began treating Mr. Erker for shortness of breath. The physician initially diagnosed COPD and asthma. Subsequently, after considering Mr. Erker's coal mine employment and denial of exposure to asbestos, Dr. Del Valle nevertheless diagnosed hypoxia due to asbestosis based on CT scan findings and other pulmonary tests.

Based on a referral from Dr. Del Valle, while aware of Dr. Erker's coal mine employment and claimed lack of asbestos exposure, Dr. Prabhu also relied on CT scan observations to diagnose asbestos-related interstitial lung disease and hypoxemia.

Seeking a second opinion concerning asbestosis, Dr. Erker turned to Dr. Kiel. Upon evaluation of the radiographic evidence, and noting Mr. Erker's coal mine employment and lack of asbestos exposure, Dr. Kiel disagreed with the diagnosis of "classic" asbestosis. He found the radiographic evidence more consistent with a fibrotic disease and diagnosed COPD.

Based on a chest x-ray, pulmonary function tests and work history, Dr. Drake diagnosed coal workers' pneumoconiosis.

After conducting a pulmonary evaluation and reviewing the medical record, including CT scan interpretations, Dr. Tuteur found sufficient evidence of coal workers' pneumoconiosis.

Likewise, Dr. Cohen also evaluated Mr. Erker's pulmonary conditions and diagnosed coal workers' pneumoconiosis. In reaching his conclusion, Dr. Cohen observed that the radiographic evidence, pulmonary function tests, and arterial blood gas produced findings consistent with pneumoconiosis.

Finally, following his extensive medical record review and interpretation of the 2002 CT scan, Dr. Renn also diagnosed coal workers' pneumoconiosis.

Concerning the nature of Mr. Erker's present pulmonary condition, the recent medial opinion is split between asbestosis and pneumoconiosis. Consequently, I must first determine the relative probative value of the physicians' opinions in terms of documentation and reasoning. Regarding the first probative value consideration, documentation, a physician's medical opinion

is likely to be more comprehensive and probative if it is based on extensive objective medical documentation such as radiographic tests and physical examinations. *Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985). In other words, a doctor who considers an array of medical documentation that is both long (involving comprehensive testing) and deep (includes both the most recent medical information and past medical tests) is in a better position to present a more probative assessment than the physician who bases a diagnosis on a test or two and one encounter. Finally, in light of the extensive relationship a treating physician may have with a patient, the opinion of such a doctor may be given greater probative weight than the opinion of a non-treating physician. *See Downs v. Director, OWCP*, 152 F.3d 924 (9th Cir. 1998) and 20 C.F.R. §718.140 (d).

The second factor affecting relative probative value, reasoning, involves an evaluation of the connections a physician makes based on the documentation before him or her. A doctor's reasoning that is both supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). Additionally, to be considered well reasoned, the physician's conclusion must be stated without equivocation or vagueness. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988).

With these principles in mind, I find that while Dr. Kiel disagreed with a diagnosis of asbestosis, his diagnosis of COPD is not well reasoned in terms of identify the underlying cause of Mr. Erker's pulmonary obstruction because he did not specifically associate that pulmonary condition with any pulmonary risk, such as Mr. Erker's exposure to coal dust and/or his cigarette smoking.

As Mr. Erker's treating physician, Dr. Del Valle was in an excellent position to provide a more probative medical opinion. However, Dr. Del Valle based his diagnosis of asbestosis on CT scan evidence which I find doubtful. Additionally, although Dr. Del Valle noted the absence of any reported asbestos exposure by Mr. Erker, his opinion is not well reasoned because he did not attempt to reconcile his diagnosis with Mr. Erker's work history.

Similarly, due to his reliance on CT scan evidence for his diagnosis of asbestosis, and failure to address Mr. Erker's work history, Dr. Prabhu's opinion has diminished probative value in terms of documentation and reasoning.

The remaining four physicians presented more probative opinions which establish that Mr. Erker has coal workers' pneumoconiosis and outweigh the contrary opinions of Dr. Del Valle and Dr. Prabhu. Based on the documentation of a complete pulmonary evaluation, Dr. Drake diagnosed coal workers' pneumoconiosis. Also relying on a pulmonary examination, and additionally possessing qualifications as a pulmonologists, Dr. Cohen diagnosed Mr. Erker with pneumoconiosis based on objective medical evidence and the presence of an obstructive and restrictive impairment in Mr. Erker's lungs. Although I found the chest x-ray evidence referenced to by these two doctors inconclusive for the presence of pneumoconiosis, the reliance of Dr. Drake and Dr. Cohen on the other objective medical evidence in the record preserves the probative value of their pneumoconiosis diagnoses. Dr. Tuteur, specially qualified as a pulmonologist, diagnosed Mr. Erker with clinical pneumoconiosis. In making his diagnosis, Dr.

Tuteur relied firm documentation basis consisting of a pulmonary evaluation, record review and CT-scans. Finally, Dr. Renn, another well-qualified pulmonary expert, provided a well documented and reasoned opinion that Mr. Erker has simple coal workers' pneumoconiosis. The physician based his diagnosis on an extensive and comprehensive review of the objective medical evidence. Although he could have provided more detail on how he reached his conclusion, his diagnosis of simple coal workers' pneumoconiosis is clearly consistent with the more probative objective medical evidence in the record.

In summary, the consensus of the more probative medical opinions of Dr. Drake, Dr. Cohen, Dr. Tuteur, and Dr. Renn that Mr. Erker has coal workers' pneumoconiosis outweighs the less probative diagnoses of asbestosis by Dr. Dell Valle and Dr. Prabhu and Dr. Kiel's finding of unspecified COPD. Accordingly, I find Mr. Erker has proven the presence of pneumoconiosis through medical opinion under 20 C.F.R. §718.202 (a) (4) (2001).

Pneumoconiosis Arising Out of Coal Mine Employment

Once a claimant has proven the existence of pneumoconiosis, 20 C.F.R. § 718.203 (a) requires that he also establish that his pneumoconiosis arose at least in part from his coal mine employment. According to 20 C.F.R. § 718.203 (b), if the claimant was employed in coal mining for ten years or more, a rebuttable presumption exists that the pneumoconiosis is due to coal mine employment.

Since the parties stipulated that Mr. Erker has at least 35 years of coal mine employment, he is entitled to the presumption that his pneumoconiosis is related to his coal mine employment. Again, while some evidence was presented concerning asbestos-related pulmonary problems, I have determined those medical assessments to be less probative. Thus, such evidence does not rebut the presumption. Additionally, the presumption is further supported by the probative consensus of Dr. Drake, Dr. Cohen, Dr. Tuteur, and Dr. Renn that Mr. Erker has coal workers' pneumoconiosis. As a result, I find Mr. Erker's pneumoconiosis is due to his coal mine employment.

Total Disability

As previously discussed, to receive benefits under the Act, Mr. Erker must prove by the preponderance of the probative evidence that he has pneumoconiosis that arose out of his coal mine employment and that he is totally disabled due to coal workers' pneumoconiosis. Returning again to the third element of entitlement, in Mr. Erker's case, he may demonstrate total respiratory or pulmonary disability through pulmonary function tests, arterial blood-gas tests, or medical opinion.

By determining that Mr. Erker has established a change in condition based on total disability since Judge Huddleston's denial of his initial claim, I have already found Mr. Erker has proven this requisite element of entitlement. Up through Judge Huddleston's July 1987 denial of his claim, the evidence in the record had been insufficient to establish total respiratory disability. However, in March 2002, an arterial blood gas study demonstrated that Mr. Erker no longer had the respiratory capacity to place sufficient oxygen in his blood stream. Moreover, almost all of

the physicians who recently evaluated Mr. Erker's pulmonary capacity, including Dr. Drake, Dr. Tuteur, Dr. Cohen, and Dr. Renn, found Mr. Erker to be totally disabled from a respiratory standpoint. As a result, Mr. Erker is also able to prove total respiratory disability through medical opinion. Accordingly, I find that Mr. Erker is totally disabled under the provisions of both 20 C.F.R. §§ 718.204 (b) (2) (ii) and (iv), establishing the third requisite element of entitlement.

Total Disability Due to Coal Workers' Pneumoconiosis

Because Mr. Erker has established three of the four requisite elements for entitlement to benefits, the award of benefits rests on the determination of whether his respiratory disability is due to coal workers' pneumoconiosis. Proof that a claimant has a totally disabling pulmonary disease does not by itself establish the impairment is due to pneumoconiosis. Under 20 C.F.R. § 718.204 (c) (1), absent regulatory presumptions in favor of a claimant, the claimant must demonstrate that pneumoconiosis was a substantially contributing cause of his total disability by showing the disease: 1) had a material, adverse effect on his respiratory or pulmonary condition; or, 2) materially worsened a totally disabling respiratory impairment caused by a disease or exposure unrelated to pneumoconiosis. Additionally, 20 C.F.R. § 718.204 (c) (2) mandates that "the cause or causes of a miner's total disability shall be established by means of a physician's documented and reasoned medical report."

As I discussed earlier, the probative weight of the physicians' opinions vary. However, the overwhelming consensus of the more probative opinions by Dr. Drake, Dr. Cohen, Dr. Tuteur, and Dr. Dr. Renn establish that Mr. Erker's total disability is due to coal workers' pneumoconiosis. Dr. Drake found Mr. Erker totally disable primarily by his lung disease, coal workers' pneumoconiosis. Dr. Cohen believes that Mr. Erker's obstructive defect with severe diffusion and gas exchange abnormality is secondary to both coal dust exposure and cigarette smoking. Dr. Tuteur states that coal workers' pneumoconiosis causes Mr. Erker to have breathlessness and hypoxemia, which render him totally disabled and unable to return to work as a coal miner. And, Dr. Renn opined that Mr. Erker has a moderate to moderately severe obstructive ventilatory defect due to coal workers' pneumoconiosis and that Mr. Erker is totally disabled and cannot perform his last coal mine job as a belt shoveler.

Since the four more probative medical opinions demonstrate that Mr. Erker is totally disabled due to his coal workers' pneumoconiosis, Mr. Erker has proved the final element of entitlement under 20 C.F.R. § 718.204 (c).

CONCLUSION

Based on recent arterial blood gas studies which met the total disability standards under the regulations, Mr. Erker is able to now prove total respiratory disability, one of the requisite conditions for entitlement under the Act previously adjudicated against him. Upon consideration of the entire record, the preponderance of the more recent and probative medical opinion establishes that the presence of coal workers' pneumoconiosis in Mr. Erker's lungs. Coal dust exposure resulting from Mr. Erker's history of working in the coal mines caused the pneumoconiosis. Likewise, the preponderance of the arterial blood gas studies and medical

opinion establishes that Mr. Erker is totally disabled. Finally, the more probative medical opinion proves that his totally disabling respiratory impairment is due to coal workers' pneumoconiosis. Accordingly, under 20 C.F.R. § 725.309, since Mr. Erker has proven all applicable conditions of entitlement under the Act, his subsequent claim for black lung disability benefits must be granted.

Augmentation

Benefits under the Act may be augmented for a person who meets the criteria of spouse under 20 C.F.R. §725.204 and the dependence requirements of 20 C.F.R. § 725.205. Based on stipulation of fact by both parties, I find Mrs. Catherine Erker is a qualified spouse and meets the regulatory requirements for spousal augmentation of Mr. Erker's black lung disability benefits.

Date of Entitlement

Under 20 C.F.R. § 725.503 (b), in the case of a coal miner who is totally disabled due to pneumoconiosis, benefits are payable from the month of onset of total disability. When the evidence does not establish when the onset of total disability occurred, then benefits are payable starting the month the claim was filed. The Benefits Review Board ("BRB") has placed the burden on the miner to demonstrate the onset of total disability. *Johnson v. Director, OWCP*, 1 B.L.R. 1-600 (1978). Placing that burden on the claimant makes sense, especially if the miner believes his total disability arose prior to the date he filed his claim. In that case, failure to prove a date of onset earlier than the date of the claim means the claimant receives benefits only from the date the claim was filed. The BRB also stated in *Johnson*, "[c]learly the date of filing is the preferred date of onset unless evidence to the contrary is presented."

At the same time, a miner may not receive benefits for the period of time after the claim filing date during which he was not totally disabled. *Lykes v. Director, OWCP*, 12 B.L.R. 1-181, 1-183 (1989). This principle may come into play if evidence indicates there was a period of time after the filing of the claim during which the miner was not totally disabled. One example is the situation in *Rochester and Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600 (3d Cir. 1989), where after the miner filed his claim, the initial probative medical opinions provided some evidence that the miner was not totally disabled, yet the administrative law judge found a subsequent evaluation did establish total disability and then set the entitlement date as the date of the claim. The appellate court affirmed the finding of total disability but believed the administrative law judge erred by awarding benefits from the date of the claim because he had not considered whether the earlier medical evaluations indicated that the pneumoconiosis had not yet progressed to a totally disabling stage. In other words, if evidence shows an identifiable period of time where a miner was not totally disabled by pneumoconiosis that is subsequent to the date the miner filed his claim and prior to a firm medical determination of total disability, then it is inappropriate to award benefits from the month the claim was filed.

However, if no intervening medical evidence raises the possibility of total disability not being present between the claim filing date and the first medical evaluation establishing total disability, then a different set of principles is applicable. In this situation, when the first medical examination after the claim is filed leads to a finding of total disability, the date of the

examination does not necessarily establish the month of onset of total disability. Instead, it only indicates that some time prior to the exam, the miner became totally disabled. *See Tobrey v. Director, OWCP*, 7 B.L.R. 1-407, 1-409 (1985) (the date the claimant is "first able to muster evidence of total disability is not necessarily the date of onset").

Mr. Erker has presented medical evidence showing that the onset of his total disability occurred before June 17, 2002, when he filed his present claim. According to Dr. De Valle's treatment notes, Mr. Erker first presented with worsening breathing problems in October 2001. A few months later, a March 4, 2002 arterial blood gas study demonstrated he was totally disabled. Since I have found that the preponderance of the recent arterial blood gas evidence establishes that Mr. Erker has become totally disabled since the denial of his last claim and the March 4, 2002 test is the first objective medical evidence of that disability, I find Mr. Erker is entitled to black lung disability benefits payable from the beginning of the first month in which he showed that he is totally disabled, March 2002. Therefore, Mr. Erker's black lung disability benefits are payable beginning March 1, 2002.

Attorney Fees

Counsel for the Claimant has thirty calendar days from receipt of this decision and order to submit an application for attorney fees in accordance with 20 C.F.R. §§ 725.365 and 725.366. With the application, counsel must attach a document showing service of the fee application upon all parties, including the Claimant. The other parties have fifteen calendar days from receipt of the fee application to file an objection to the request. Absent an approved application, no fee may be charged for representation services associated with this claim.

ORDER

The claim of MR. TOM ERKER for benefits under the Act is **GRANTED**. PEABODY COAL COMPANY is ordered to:

1. Pay Mr. Tom Erker all benefits to which he is entitled under the Act and Regulations, augmented for his dependent spouse, Mrs. Catherine Erker. Benefits shall commence March 1, 2002;

2. Reimburse the Black Lung Disability Trust Fund, pursuant to 20 C.F.R. § 725.602 (a), for all interim payments made by the Black Lung Disability Trust Fund to Mr. Tom Erker, with interest;

3. Deduct from the payments ordered in paragraph one, as appropriate, the amounts reimbursed to the Black Lung Disability Trust Fund as directed in paragraph two.

SO ORDERED:

A

Richard T. Stansell-Gamm
Administrative Law Judge

Date Signed: November 30, 2004
Washington, D.C.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision is filed with the District Director, Office of Worker's Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN.: Clerk of the Board, Post Office Box 37601, Washington, DC 20013-7601. *See* 20 C.F.R. § 725.478 and § 725.479. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, DC 20210.

Attachment No. 1

American Board of Medical Specialties
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Attachment No. 4

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Attachment No. 6

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